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BULLETIN

THE MAHONING COUNTY MEDICAL SOCIETY
Volume LIX Number 7 October1989

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BULLETIN

MAHONING COUNTY MEDICAL SOCIETY

Volume LIX October 1989 Number 7

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The Bulletin is published nine times a year monthly with the exception of May, July & August, by the Mahoning County Medical Society, 5104 Market St., Youngstown, OH 44512. Ph. 216/788-4700. Eleanor Pershing, Executive Director

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President's Page

Karl F. Wieneke, M.D.

Catastrophic Health Plan .....Is it a good buy? As you all know, Medicare's beleaguered catastrophic illness program, which was enacted by legislators during the past year and which is scheduled to be implement during the coming year is being besieged from all sides. The controversial program is already under attack from many of the seniors whose income related premiums or surtaxes are its primary financing. Some apparently object to paying for coverage that they already have and, therefore, feel they don't want and don't need. But almost all of the elderly beneficiaries object to having to pay the premiums themselves rather than financing premiums by general tax revenues. Recently it has come under fire again with the announcement that the five-year cost of the new program may be 50% higher than Congress anticipated when the bill was enacted. The Congressional Budget Office has placed the cost at 43 billion dollars over a 5 year period and this would put the program 6 billion dollars in the red by 1993. Many members of Congress are therefore questioning the wisdom and value of the program. In addition, it has been said that this bill has generated more and stronger negative comments from constituents to their congressmen, than any other legislation in memory. Apparently many feel this is an idea whose time has not come! For these reasons it is almost certain that the program will be drastically amended by Congress and perhaps even completely repealed.

There is, however, one benefit that is part of the Catastrophic Illness Act that should be retained, the medical payment of screening mammograms. Until now, Medicare has refused to pay for screening mammograms. But this legislation makes this benefit available to 17 million women over age 65. It would also screen younger disabled women in the Medicaid category. Generally the program would cover one mammogram every two years and more frequently for certain high risk women. It also covers the physician's office breast exam. This is important because breast screening for cancer is incomplete with mammogram only. Today fewer than half of all women over age 50 have a mammogram at least once every two years. But officials of the Health Care Financing Administration estimate that by 1995 over 75% of eligible women will take advantage of the new coverage. In approving the new benefit, Congress considered the data showing that one in every eleven American women developed breast cancer at some time in life and that about 43,000 women die each year of the disease, more than half over the age of 65.

Organizations such as the American Cancer Society, the American College of Surgeons and the American Public Health Association who have pushed for more extensive screening, are pleased that Medicare has made screening mammograms the first exception to its prohibition on payment for routine physical check-ups.

Now, however, this new benefit is in jeopardy, due to the likelihood of drastic

changes or repeal of the overall Catastrophic Illness Act. Most certainly we physicians through OSMA and AMA and other politically active groups should lobby Congress to retain this worthwhile benefit. In addition, we as individual physicians can call or write members of Congress — and encourage our patients to do so as well — urging that this coverage be retained. Hopefully in 1990 screening mammograms will remain as a permanent benefit for our Medicare patients. Let's not throw out the baby with the bath water!

Physicians For Research In Cost-Efficiency

A new organization, Physicians For Research In Cost - Efficiency (PRICE) has been founded by Dr. David Shulkin, Pittsburgh, Pennsylvania. The goal of the organization is to facilitate communication about low-cost quality medical information among physicians involved in research, academics, administration and practice. A newsletter will provide information on research efforts, political trends, clinical observations and practice innovations for the practice of cost-effective medicine. PRICE will also serve as a clearinghouse for conferences, new job opportunities, and training options for physicians interested in cost issues in medicine. For membership information contact David J. Shulkin, M.D., President, PRICE, 926 Bellefonte St., Pittsburgh, PA 15232, (412) 682-8015.

From the Desk of the Editor

Brian S. Gordon, M.D.

THE PUBLIC SECTOR

We in medicine have always regarded ourselves as the advocates of health. Before the turn of the present century, this was virtually the case world wide, except for a few religious dietary laws and grandmothers slaving over hot pots of chicken soup. This century saw the blossoming of the industrial revolution and with it the increased complexities of medicine.

Health was then divided into two divisions - the private and the public sectors. The private sectors eventually were forced to specialize and give up part of the advocacy to industry, pharmaceutical companies, Reader's Digest, and countless societies, preachers and almost anyone else who wanted a "piece of the pie"! So too has the public sector been divided. Local health departments under the auspices of state and federal agencies have lost control of their mandated missions.

While most physicians understand that food service inspections, birth and death records, water and waste disposal, dissemination of various vaccines, compilation of infectious disease records, and dispersion of epidemic statistics and other vital statistics are within the scope of the health departments, most are unaware that the same outside influences on medicine are destroying them too.

Many doctors fear that a completely socialized system will not only change significantly the private sector but will probably destroy the local health departments. Already AIDS, drug abuse, toxic waste, air and water pollution, auto safety and many other issues are handled by lay government agencies.

In order to combat this, a new awareness is growing within all health agencies that political power is the only way that their organizations can survive. In Ohio, this also means that the "fat" has to be taken out and a "lean, mean fighting machine" has to take over.

In the near future, city, county, and state agencies will be bombarding their governing boards for consideration of major changes.

Here in Mahoning County, the health departments are divided into a county health department and five municipal health departments, most of the latter existing on a small and inadequate basis. The two largest districts, the city of Youngstown and the Mahoning County Health Department take the lead for the county.

In the next several months, these two districts will be melded into one unit, thanks to the leadership of the two commissioners and their respective boards. It is hoped that the other districts eventually do the same. This will give at least Mahoning County a jump on the future. Support for our health departments is in our best interest. Let us hope they succeed. People's health depends on it.

Medical Decision Making

Leonard P. Caccamo M.D. FACP

Problem Based Learning

An Analytic Approach to Informed Consent

Leonard P. Caccamo M.D.
Kimbroe Carter M.D. • W. Robert Kennedy Phd

We shall begin this month's column with a definition of terms common to the literature of both general and medical education. They are provided for your understanding:

1. WHAT ARE PROBLEMS AND QUESTIONS?

A PROBLEM is a psychological state of uncertainty, a goal not reached, a mental state of disequilibrium sometimes possessing external validity and other times exhibiting preferences. In contrast a QUESTION is a closed ended inquiry usually requiring a known answer. It may be systematically represented with a model diagram illustrating a branch or pathway leading to a decision or analytical outcome. The most elementary use of a question is to prod the student to regurgitate learned material. A question should arouse and motivate and if one responds without such arousal, he or she is engaged only in a circular EXERCISE without direction. A problem of any complexity engenders an intellectual process or open ended inquiry. Questions that evolve from such activity are important, however, they must stimulate the DISCIPLINED THINKING required for effective clinical problem solving. Remember that last month we defined disciplined thinking as an objective and analytical method for solving well defined problems by weighing major alternative pathways and outcomes, with the chain of thought moving along lines of greatest probability, outcome values and/or utilities. Probabilities and clinical preferences (utilities) come from such external sources as the medical literature. Ultimately, however, the patient's personal preferences must be thoroughly explored in the light of clinical judgement so that they can also be effectively incorporated into outcome values! UTILITIES AND VALUES are applied to endpoints or outcomes.

A MEDICAL PROBLEM is defined as any patient complaint or finding that ultimately prompts the physician to DECIDE on one or more of the following actions:

- DIAGNOSIS (obtain more data)
- PATIENT EDUCATION AND MEASUREMENT OF PATIENT PREFERENCE (information provided about prognosis and reasons for action or non action as well as measurement of patient preferences for such behavior.)

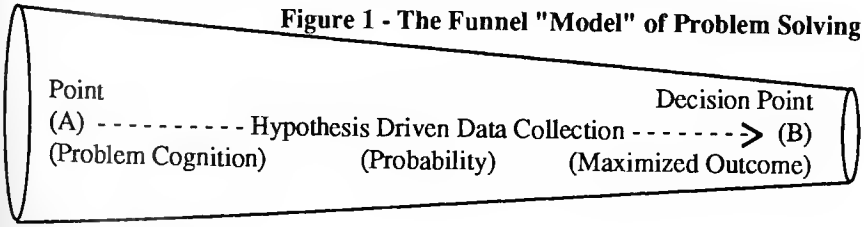
• TREATMENT WITH RESPECT TO PATIENT PREFERENCE (surgery, medicine, other) Analysis of the problems of diagnosis, treatment, prognosis and patient preference are matters of chance. This approach mandates that physicians besides learning to "classify the classifiable" and "measure the measurable" must also master the science of lottery or gambling to help the patient best quantify his or her own personal preferences.

Classical medical teaching lumps or splits the data qualitatively or quantitatively using the following three levels of measurement: **1.** nominal (qualitative) 2. ordinal (semi quantitative) **3.** interval (quantitative).

Medical signs, symptoms, syndromes and diseases are qualitative or semi quantitative in nature and as such present some initial difficulty with classification. Such classification requires that findings must fulfill 3 requirments: All clinical findings must be (1) well defined by the observer, (2) exclusive so that no finding can belong to more than one category, and (3) exhaustive, meaning that all possible findings must belong to one of the categories. These stipulations pose a particular difficulty for medicine because all physicians do not agree on the definitions for many of the major clinical findings. Authors of textbooks and editors of journals should, but often do not, strive to standardize such terms.

Nevertheless, the physician must begin with the patient's story and presenting complaints which requires classification and appropriate measurement. Every attempt should be made to use standard definitions and to strive for maximum accuracy through meticulous questioning. Nonetheless the physician must also sense various levels of certainty with respect to his classification. Blois[1] has represented this complex decision making process of differential diagnosis and problem solving as a funnel with problem cognition near the broad opening POINT A and maximized decision making outcomes near the spout POINT B. It remains important to recognize that data collection remains a continuous hypothesis driven process moving form the general to the specific as one progresses down the funnel. The decision point represents the maximized outcome of all the major potential outcomes analyzed in the context of the uncertainty surrounding the problem. We have taken the liberty of modifying this funnel model and sketch it below:

Figure 1 - The Funnel "Model" of Problem Solving



THE CLINICAL PROBELM SOLVING PROCESS

When one considers the entire problem solving process, most experts agree that the following sequential strategies take place from the starting point of problem cognition along probability pathways to the ultimate endpoint of a decision based upon an optimum outcome.

Step 1 - PROBELM COGNITION with pertinent data classification and interpretation

Step 2 - Defining START AND ENDPOINTS for patient management from recognizable PATTERNS that are assembled and compared.

Step 3 - Major HYPOTHESIS generation and sequential pathway structuring linking start and endpoints.

Step 4 - Selection of high yield pathways and choosing the most PROBABLE hypotheses and their validation.

Step 5 - Defining SENSITIVE DECISION VARIABLES which cause different pathways to be selected.

These stages are rapidly covered by expert clinicians, less rapidly by those in training, less adept in decision analysis. The key elements must be viewed from the "skill perspective". SKILL may be defined as how clinicians analyze their past problem solving experiences to generate models, and how they apply such models to current problems.

STEP 1 - PROBLEM COGNITION: Sensing Key Clues and Pivotal Patterns in the FIRST 5 MINUTES

The first step in patient applied medical decision making process occurs, according to Moser[2] within the first 5 minutes. This action is initiated at the wide end of the funnel (Point A). The patient's chief complaint is the point of entry. Here the clinician is faced with great uncertainty and, upon questioning the patient, potentially hundreds of possible elementary findings are conceivable. An elementary finding is any single symptom, sign or laboratory result. The physician begins his quest by attempting to sense the problem(s) based upon certain preliminary information such as the presenting complaint, age, race, sex, and appearance. Within this preliminary data the clinician searches for the presence or absence of "key clues" that may suggest a diagnostic pattern! This activity serves to progressively reduce the size of the problem into a limited number of major aggregates based upon a strong belief or presupposition that there is a potential hierarchial structure to the classification schemes applied to the patient's findings.

STEP 2 - Defining START AND ENDPOINTS for patient management from recognizable PATTERNS that are assembled and compared.

Pattern recognition is a unique biological phenomenon, the nature of which is

still poorly understood. It consists in an almost instantaneous recognition of certain clues within the first 5 minutes and the recognition that these findings are members of an aggregate or cluster of related findings belonging to a pattern. Search continues to complement and build this pattern by exploration for other missing parts.

It is during basic medical training in medical school and residency that the physician begins to develop the framework for classifying and storing a series of such meaningful patterns or pictures. It appears that these "pictures" may be stored like holograms in the brain and reinforced by a lifelong continuing education process of daily problem directed learning! Problems are thus framed within the context of meaningful past experiences probably as picture-stories. According to Kassirer[3] clinicians identify this context or relationship on the basis of a small initial number of clues, patterns and/or pathological processes.

Consider the following emergency room probelm of a 62 year old white dentist presenting with the cheif complaint of crushing substernal chest pain of one hour duration. The patient has come to the emergency room at his limit of tolerance because the pain is severe.

Isolating a chief complaint, such as chest pain, identifies the START point which serves as a constant reminder of two important facts. It clearly identifies a serious reason why the patient seeks care as well as the difficulty for which the patient anticipates treatment or the answer as to why no treatment is given. Once the patient's complaint has been identified (Problem Cognition), within the first 5 minutes, the physician then seeks to define the pain by an appropriate algorithmic method which one of us has called the PQRST model.

P = previous episodes, precipitating or relieveing causes.
Q = quality of pain
R = radiation
S = severity
T = duration or recurrence

Appropriate data collection quickly determines if the pain is or is not ischemic and of serious consequence. Having identified the pattern of possible ischemic SIX DERMATOME CHEST PAIN the question is then: what hypothesis should be considered and tested first? We shall return to these questions in STEP 3 below.

On occasion elementary findings may be a pathognomonic clue limited to a single disease (e.g. the Kayser-Fleischer ring of Wilsons disease), more often they may suggest a limited set of potential diagnoses as in the six dermatome chest pain list or in a syndrome cluster like congestive heart failure. Lacking a highly diagnostic finding or if the symptoms are vague and hypotheses difficult to

generate, the physician may shift into low gear using the routine questioning of the "method of exhaustion" taught in medical school until a pattern evolves. He may also begin considering the major pathological processes and generate a "list" of potential CAUSES.

This can be well illustrated by the problem of fever of undetermined origin (FUO). Experience plays a role in creating "lists" of causes and most of us have difficulty remembering them. In addition we have to face the age old paradox that "if we don't know what we are looking for we won't recognize it when we see it."

STEP 3 - Major HYPOTHESIS generation and sequential pathway structuring linking start and endpoints.

The physician now begins to complete and match hypotheses about possible causes or etiologies in the search for a specific diagnosis, or solution. A clinician's past experience largely determines the number, complexity, and range of hypotheses generated. The more experience one possesses, the more potential hypotheses generated! However, the expert limits or prunes his or her structure to pertinent ones.

Let us now return to the differential diagnosis of ischemic SIX DERMATOME CHEST PAIN PROBLEM. Having identified this distinctly possible pattern the physician must now progressively narrow the possibilities to a limited number of similar problems unique to the same anatomical area and serious enough that the doctor can not afford to miss them:

THE DIFFERENTIAL DIAGNOSIS LIST
OF SIX DERMATOME CHEST PAIN

1. Myocardial Infarction
2. Pulmonary Embolism
3. Acute Pericarditis
4. Dissecting Aneurysm
5. Pneumothorax
6. Ruptured Esophagus
7. Pneumonia
8. Acute upper abdominal emergency:
   - Penetrating or Ruptured Peptic Ulcer
   - Acute Pancreatitis
   - Acute Cholecystitis

As you can quickly see these hypotheses include many diseases that result from a number of the following major pathological processes: (e.g. ARTERIOSCLEROTIC, VASCULAR, IDIOPATHIC, INFECTIOUS OR INFLAMMATORY, TRAUMATIC, METABOLIC, NEOPLASTIC, ALLERGIC, NUTRITIONAL,

OR GENETIC)

So far, the physician has not been concerned with probability of one cause or disease but only with the presence or absence of a pivotal finding and the generation of a list of problems that may have precipitated such a finding. These hypothesis now serve as a framework (context) for the next aspect of the diagnostic process.

STEP 4 - Selection of high yield pathways and choosing the most PROBABLE hypotheses and their validation.

During this phase the physician reviews the list of hypotheses one at a time and compares the general clinical pattern of the disease in question with that of the specific case at hand. Since pivotal findings have been used to construct hypotheses some will be more plausible than others. Additional information is generated by purposefully directing questions. Here we find continuation of the hypothesis driven information data gathering. The strategy serves partly as a basis for configuring a set of findings that should be PRESENT or ABSENT to confirm or refute a suspected diagnosis. Each new piece of information, found or not found, is then weighted as to its probability in confirming or negating the hypothesis. This process sets the stage for asking further questions and the cycle repeats itself until the clinician is satisfied that an hypothesis is firm.

In a classic study by Shulman[4], it was shown that master clinicians may rank hypotheses using the patterning principles of: (a) Seriousness, (b) Treatability, (c) Probability, and (d) Novelty. Whereas many hypotheses are possible at the onset, the field of possibilities becomes rapidly and progressively narrowed.

1. Seriousness: Life-threatening or incapacitating conditions are ranked higher than their population base-rate warrants. These may be less probable but they are problems the clinician can not afford to miss. This criteria was applied to the case of the six dermatome chest pain under the rubric of "problems we can't afford to miss".

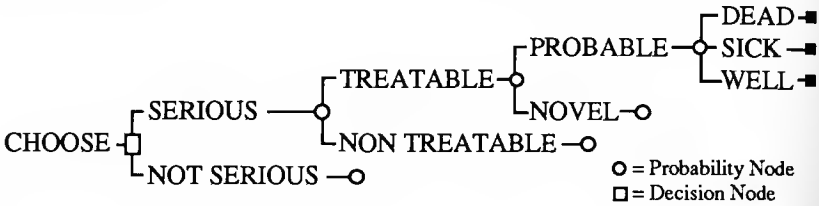
2. Treatability: Given two equally serious diseases, the treatable one is ranked higher so as not to overlook any treatment which might possibly be helpful. Again if you refer to the six dermatome chest pain list one can easily see the danger of premature closure on the most common and likely diagnosis of myocardial infarction at the expense of not recognizing or treating some of the other serious but less probable conditions.

3. Probability: Subjective estimates are made of the statistical likelihood that a particular disorder is causing the patient's problem. The estimate may closely approximate the population base-rate (prevalence) for that disorder.

4. Novelty: Some physicians deliberately seem to entertain hypotheses which they know are improbable. The very remoteness of the propsed formulation makes

it attractive and this strategy serves two functions. First it keeps the physician interest at a high level and insures that unlikely avenues are explored. Secondly it protects the patient from a premature closure on a more probable hypothesis which in a particular case may be in error. (Often referred to as "shooting from the hip") One can see how thinking of ruptured esophagus or dissecting aneurysm could play a very similar role in the differential diagnosis of myocardial infarction.

These criteria may be modeled in the following decision tree structure for a more graphic understanding of the process. It should be understood that each of the TREATABLE AND NON TREATABLE entitles could also present dualistic pathways of PROBABLE AND NOVEL and the three disease outcomes of DEAD SICK AND WELL.



Depending upon the nature of these "rules of thumb" or hierarchial patterns from a clinician's personal experience and problem directed reading, hypotheses may thus be weighted in different ways. The importance of novelty, for example, may be far greater for a specialist in a referral clinic than it is for a family doctor in community practice. Novel hypotheses may also be generated by a recent journal article, grand rounds or informal talks with colleagues over a cup of coffee. Serendipidy may be valuable but it may also be a bear trap that can lead down a blind alley.

The entire diagnostic process is thus goal directed and built upon the systematic mental processes of data collection, modifying hunches, and exploring other possible explanations in order to define a diagnosis for the one or more problems at hand. One can easily see why these steps can be accomplished so intuitively and efficiently by "expert or master" clinicians, with their appropriate treasury of picture clues. The "patterns" and conceptual explanatory concepts from past experience are quickly compared with the current clinical situation and the physician need not become lost within the chaos of numerous clinical details. Unfortunately at present the more formal disciplined thinking of decision analysis is infrequently used by the average physician to weigh findings or quantify all of the potentially significant pathways and outcomes.

STEP 5 - Defining SENSITIVE DECISION VARIABLES which cause

different pathways to be selected.

Having interpreted the data and structured the links between the problem and its outcome, the physician must now take one and/or more of the decision variables (e.g. probabilities or utilities) and alter their numerical values in order to test the stability of the pathway which currently gives an optimal or maximized outcome. Ultimately, the patient's preference is incorporated into the process. This is always important! What does the patient already know and what additional information must be given for the patient to confront the diagnosis, the planned therapy, the regimen to be followed, or even the changes in life-style required. What does the patient "think" he has or "fear" will happen? The physician has now come full cycle from chief or presenting complaint to possible solution, prognostic implications, and the best alternative to follow. This requires the evaluation of patient preference to help construct a patient VALUE measurement or scale. At Point B probability and value theory are combined to make the best management decision. The power of decision analysis permits both doctor and patient to invoke "what if" strategies called sensitivity analysis to determine the best course or action for the individual patient based not only upon data obtained from published controlled clinical studies but also upon the individuals own personal value judgements. The computer programs are currently freeing medical thinking so that it can quickly explore, before the fact, alternative outcomes of different management scenarios. These can be illustrated on the screen in clear graphic form for both patient and doctor to consider and discuss both risks and benefits. Informed consent now may be documented!

In summary, this article has presented the framework of disciplined thinking as applied to medical decision making and clinical judgement. Next month we shall explore some to the tools of the decisoin analyst and the meanings of prevalence, sensitivity, specificity and positive predictive value!

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Clyde Gardner

News from NEOUCOM

Health Professions Students Learn to Deal With "Real" People

I was lazily scanning the student evaluation of one of our recent Area Health Education Center (AHEC) clinical training projects. As I read some of the comments aloud, I paused and reflected on having made the same observation some 20 years ago.

It's amazing how time flies, how fast things change, and yet how they stay the same.

"It was the first time I got to work with a group of people I never really interacted with before," said one student, who had given a presentation to black children at the Youngstown Boys Club.

"This experience was good because it gave me a different perspective on the problem (delinquency)," wrote another student who spoke with teens at the Youngstown Juvenile Justice Center.

These comments came from a group of white, middle-class health professions students from Youngstown StateUniversity. The students were taking part in an interdisciplinary clinical training project coordinated by AHEC which provides community-based clinical training for students in professions for which there is a continuing need for additional practitioners. Their assignment was to develop a patient education program and present it to one of several grass-roots, minority, black or Hispanic community-based programs.

These clinical training experiences, combined with didactic sessions, help to vividly illustrate the relationship between theory and practice.

Comments such as "They didn't seem attentive" or "The kids were too noisy" brought a well-organized, practice education program to a screeching halt. It also left the students unable to deal with the practical realities of working with real people in real situations.

This was further evident since the "real" people did not share the same values, the same economic status, and in some situations, not even the same language, as the students.

But the students learned from their mistakes and their second presentation to a similar group went better - not great or perfect - but better.

The student comments heard after the first session were eager and to the point. "I think we should change this or add that" or "Let's start from the end and go to the beginning."

What did the students learn? They learned that presenting complex information only by language often causes confusion and lack of understanding. They learned to take more time to prepare, to use visual aids, and to use analogy or humor to illustrate abstract thoughts.

They learned to tailor their session to the age and educational level of the audience and to be competent and humane. And they learned that collaboration with other health professions students, in this interdisciplinary project, fosters mutual appreciation among fellow soon-to-be working professionals.

The students also received reinforcement of things they had already learned:

* children born and reared in poverty are especially vulnerable to death and disability;

* more children live below the poverty level than any other group;

* one in every five children lives in environments where housing is substandard, nutrition is poor, stress is high and primary or preventive health care is inadequate or nonexistent.

The clinical learning experiences also gave students the opportunity to test their choice of professions, to see first-hand if they could function in "real" situations with "real" people.

After finishing my review of the student evaluations, I placed them on my desk, swung around in my chair to look out on Market Street and reflect on what I had read.

Yes, they had learned some vital lessons about individual and group behavior and its relationship to health care. They had learned about individual responsibility for one's own health and the many health consequences that poverty creates for women and children.

Yes, it was a good learning experience for us all.

Editor's Note: Clyde Gardner is director, Mahoning-Shenango Area Health Education Network (MsAHEN), an Area Health Education Center (AHEC) affiliated with Northeastern Ohio Universities College of Medicine. MSAHEN contracts with Youngstown State University to support nursing, nutrition and other allied health programs in urban and rural hospitals, health departments and agencies, and community health clinics. The Ohio Statewide AHEC program provides a unique link between medical and other health professions schools and underserved communities in Ohio. The program is designed to help these communities improve their ability to support health care services and to prepare students to practice in these communities.

From the Bulletin

Robert R. Fisher, M.D.

FIFTY YEARS AGO – OCTOBER 1939

The depression was over and the State relief law had been changed so that medical relief was on the same footing as work relief. The County Commissioners were responsible for the indigent sick at home, but the Township Trustees were responsible for hospitalization.

A poll was taken of the membership and they voted to change the doctor's afternoon off from Thursday to Wednesday. Before long, everybody had drifted back to Thursday.

David Belinky, A. Rosapepe, Fred Coombs and Vern Goodwin were taken in as new members.

FORTY YEARS AGO – OCTOBER 1949

The first Diabetes Detection Drive was under way directed by a committee consisting of Morris Rosenblum, Arnoldus Goudsmit, Fred Coombs, Stanley Curtis, Herman Ipp, Bob Kiskaddon, Milt Yarmy, Harold Reese, Walter Tims, Elmer Wenaas, Howard Mathay, Pat Kennedy, J.R. Buchanan and Gabe DeCicco.

St. Elizabeth Hospital Staff announced the formation of a "Polio Team", consisting of a pediatrician, physiotherapist and an orthopedist to care for (poliomyelitis) cases.

Sixth District Post-Graduate Day was announced for November with a group here from the Lahey Clinic. A.K. Phillips headed the committee.

THIRTY YEARS AGO – OCTOBER 1959

President Neidus expressed special thanks to H.P. "Mac" McGregor for a wonderful job on the Canfield Fair Committee. Editor Lester Gregg wrote: "Width the advancement of medicine, the role of the general practitioner becomes more complex...He should be a part of the hospital team and not relegated to a lesser role as he is in many hospitals."

The leading article that month was "Poliomyelitis; Complications and Treatment" by William D. Loeser.

TWENTY YEARS AGO – OCTOBER 1969

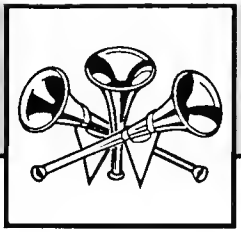
The Canfield Fair Medical Exhibit was still being held in a tent, but was getting better every year. This year they could boast of a new concrete floor. The committee, as usual, was made up of Jack Schreiber, chairman, plus Fred Friedrich and Art Resch. The exhibit featured the eye, and was entitled "We See". Many of the local ophthalmologists took time out to man the booth.

Drug abuse was on everybody's mind. Dr. Ed Pichette, chairman of the Drug Abuse Committee, arranged for three episodes of WFMJ's TV "Spotlight" Series to be devoted to the subject of drug abuse. Participating physicians were Dr. Charles Waltner, Dr. Bob Jenkins and Dr. Joe Tandatnik.

TEN YEARS AGO – OCTOBER 1979

The Canfield Fair Medical Exhibit now had a permanent home in a solid wooden building, no more tent. That year the fair attendance hit an alltime high of 539,437. Again the Canfield Fair Committee consisted of Jack Schreiber, Fred Friedrich and Art Resch, with the addition of John Melnik. No comment was made as to what the Society's exhibit was about.

Two deaths were reported: Dr. Morris W. Neidus, at the age of 79, and Dr. Joseph V. Newsome, at the age of 55. Both died of a heart attack. Both did family practice, both were active in the Medical Society, with Dr. Neidus serving as president in 1959. Their deaths left a large vacant spot in the medical community.



Fall Seminar

MEDICAL ASSISTANTS

AAMA-OSSMA

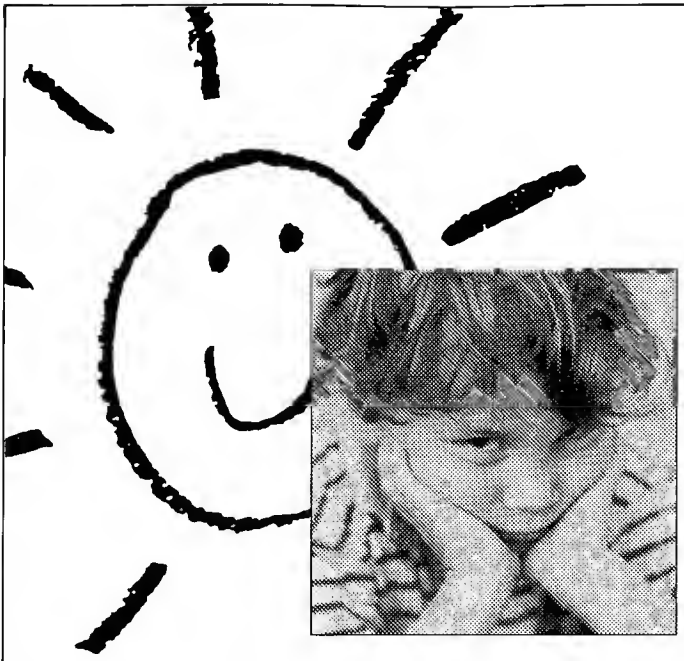
Mahoning County Chapter

FALL SEMINAR

Sunday, November 19, 1989 • 8:00 a.m. - 3:30 p.m.

Maronite Center - 1555 S. Meridian Rd., Youngstown

CEU's Being Applied. Students and Guests invited to attend. Call 758-2630 for details.



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The Caring Program is endorsed by the Ohio State Medical Association and the Ohio Chapter of the American Academy of Pediatrics.

COMMUNITY MUTUAL
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THE STRENGTH TO LEAD

The Associate Dean's Column

W. Robert Kennedy, Ph.D.
St. Elizabeth Hospital Medical Center

What Are The Benefits Of Students Working With Practicing Physicians?

Physicians, regardless of their discipline, obviously come in many varieties. There are common threads, however, that unite them. In general terms, they are compassionate and humanistically oriented human beings who wish to assist others to have a better quality of life through good health. To this end, they are available for the diagnosing and treatment of problems. In terms of their fund of knowledge, it may be difficult to quantitate in terms of a traditional medical school curriculum definition, i.e., they have homogenized their knowledge, they have not specifically categorized it along the lines of biochemistry, pharmacology, anatomy, and physiology. Through their training and experience, this information base has expanded so that they see the world in more general terms. They also acquire skills, most difficult to teach, which enable them to identify through cues, signs, and symptoms, the nature and scope of medical problems and to plan appropriate treatment plans. This synthesis of skills and understanding is a most difficult area for the medical student to acquire.

Nevertheless, the general physician, practicing within his area, has a tremendous fund of such information to provide medical students. It has credibility which is often difficult to identify, i.e., when compared with the lecturing physician teacher who presents information at a basic level. The practicing physician often does not have such an "organized" fund of knowledge, but in terms of a given patient and a given problem, he relies heavily upon pragmatic experiences that have shaped his behavior and skills and which enable him to effectively diagnose and treat the individual patient.

In medical education, our students are provided a curriculum during their first four years of our six-year program which contains a tremendous fund of specific factual knowledge, scattered across a wide spectrum. Yet the purpose and intent of their clinical experiences during the last two years is to assist them in gaining certain insights that will allow them, as their colleagues before them, to homogenize this incredible mass of information into a practical pragmatic base for understanding and dealing with the problems of individual patients.

In terms of the practicing physician, the time spent with one or two students in a clinical setting suddenly has great educational significance. The issue is not

presenting them with additional factual information, but rather helping them to comprehend, manipulate, and synthesize the information they may already possess. The skillfull physician-teacher at the bedside or in the clinical setting, whether he be office or hospital based, is that individual who can assist the student in moving from symptoms and signs, whether verbal or non-verbal, to an accurate diagnosis and the development of a logical and sequential treatment plan. To accomplish this, the student must have role models. The practicing physician, because of his experience, is that optimum role model. He thus provides a guidance system for the learner, i.e., he can assist the student in understanding how he moves from initial observations through logical diagnostic steps to the ultimate diagnoses and development of appropriate treatment plans.

One unfortunate aspect, however, is that the physician-teacher often errs in the selection of the information presented to the student. Of critical importance is the logic of how he, as preceptor, identifies and defines problems prior to selecting treatment. To be able to have an opportunity to work with an experienced practicing physician who verbally communicates the steps in his sequence of thoughts is a most valuable experience for the student.

In the early 1970's research was conducted at Michigan State University using clinicians who were identified by their peers as outstanding problem solvers. It was found at that time that clinicians of this caliber tended to all use similar problem solving strategies. As a matter of fact, their strategies were textbook in orientation; that is, one could document the steps they used in the logical progression from problem identification through solution.

However, where they differed was within the speed with which they traveled down their logic trees and made conceptual leaps from one point to another, i.e., the physician seeing one set of signs and symptoms could easily, because of experience, leap to the possible conclusion of three or four different clinical entities. By experience alone, he could narrow this down to one or two diagnoses. In so doing, to the observing student, he had gone from signs and symptoms to diagnosis with such rapidity tha the question naturally would occur as to the legitimacy of the diagnosis as well as its authenticity. Careful review, however, by researchers has demonstrated that this was "experience providing insight."

NEOUCOM students rarely have afforded to them the opportunity of having a physician work through diagnosis on a specific patient in terms of role modeling for the student's benefit. We often find our faculty caught in the trap of presenting the obvious together with a tremendous fund of information so that the student either is overwhelmed or is lost in the universe of facts and figures with the price being the logic that was used for the ultimate solution.

Practicing physicians who teach should break down the barrier of defensiveness and not compare themselves with colleagues who may be afforded greater luxury because of the specific information in a narrow subspecialty field. They can make a major educational impact upon students if they do nothing more than role model the logic of their own thinking processes.

To the practicing physician in his office with a student as an observer-participant, the opportunity to discuss a case prior to seeing a patient, assisting in the history and physical examination, then having the opportunity of later discussing that patient's problem(s) can provide tremendous insights and new learning in the area of manipulation of already held information.

Another benefit of the practicing primary care physician which cannot be overlooked is the fact that his patients are his own, i.e., there is a high degree of ownership. This has critical significance in light of the fact that he cares and demonstrates compassion for those in his charge. To the medical student, seeing patients in a clinical situation where continuity of care may not be present and where different physicians at different times provide assistance to patients in need, may not provide a true picture of the clinician's thinking process. The practicing physician knows his patients, families, their problems, and needs. This information is extremely valuable to students for it provides a background as well as a rationale for appropriate tretment.

We hope more practitioners will develop clinical office-based electives for our students. It is most important and meaningful when done correctly and enthusiastically.

The above article, still relevant today, was taken from CONVERGENCE (Vol. III, 3, 1982).

W. Robert Kennedy, Ph.D.

Who cares more about your malpractice insurance?

An insurance company run by insurance men? Or an insurance company run by doctors?

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November 10, 1989 ..... PREVENTIVE MEDICINE

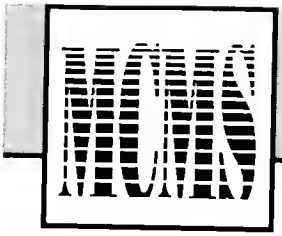
DAN FINTEL, M.D., Assistant Professor of Medicine, Chairman, Medical Utilization Review Sub-Committee, Northwestern Memorial Hospital, Chicago, Illinois, a PARKE-DAVIS Visiting Fellow, *"Practical Approach to the patient with a Lipid Disorder"*

November 17, 1989 ..... RHEUMATOLOGY

SCOTT A KALE, M.D., Assistant Professor of Medicine, Rush Medical College, University of Chicago, Director, Arthritis Center, Mount Sinai Hospital, Chicago, Illinois, a PFIZER Visiting Fellow, *"Approach to Office management of Geriatric Rheumatology"*

November 24, 1989 ..... THANKSGIVING HOLIDAY

No Program Scheduled For This Date



Meetings

Society Meeting

Ms. Nancy Kintzel, Field Representative, Medical Society Relations AMA, was the featured speaker for the September 19, 1989 Society meeting. Ms. Kintzel's topic "Perspectives on U.S. Health Care and Legislative Issues" included the issues of Mandated Health Benefits, Self Referral and Expenditure Targets. Commenting on Expenditure Targets, she noted that the AMA endorses Practice Parameters as an alternative to Expenditure Targets in that they allow the flexibility needed to maintain the individual nature of care essential in the patient/physician relationship.

Reports were given on the Canfield Fair, the Ohio Department of Insurance Hearings and the MCMS Foundation.

The following Resident applications for membership were announced:

Mohamad H. Alnahhas, M.D.
Milagros Arroyo, M.D.
Elizabeth K. Baranowski, D.O.
Mary Ellen Barringer, D.O.
John R. Becker, M.D.
Gregg L. Bogen, M.D.
Mary Ann Cater, D.O.
Thomas Crain, M.D.
Hamed A. Elfeky, M.D.
George G. Ellis, Jr., M.D.
Pablo Garcia, Jr., M.D.
Efrem Gubieda, M.D.
Myint Htwe, M.D.
Rickie K. Monroe, M.D.
Kathleen S. Padgitt, M.D.
William M. Quirk, M.D.
Zein I. Saalouke, M.D.
Gilberto Seco, M.D.
Moises M. Soulas, Jr., M.D.
Jose A. Villaplana, M.D.
Michael A. Weaver, M.D.
Michael E. Wegener, M.D.
Karl Wieneke III, M.D.
Janet L. Weinberg, D.O.
Mohammad Yaseen, M.D.

Council Meeting

The following application was presented and approved during the Oct. 10, 1989 meeting of Council. The applicant will become a member of the Mahoning County Medical Society 15 days after his name has been published in the October issue of the Bulletin that is mailed to all members, unless an objection is received in writing by the executive director before that effective date

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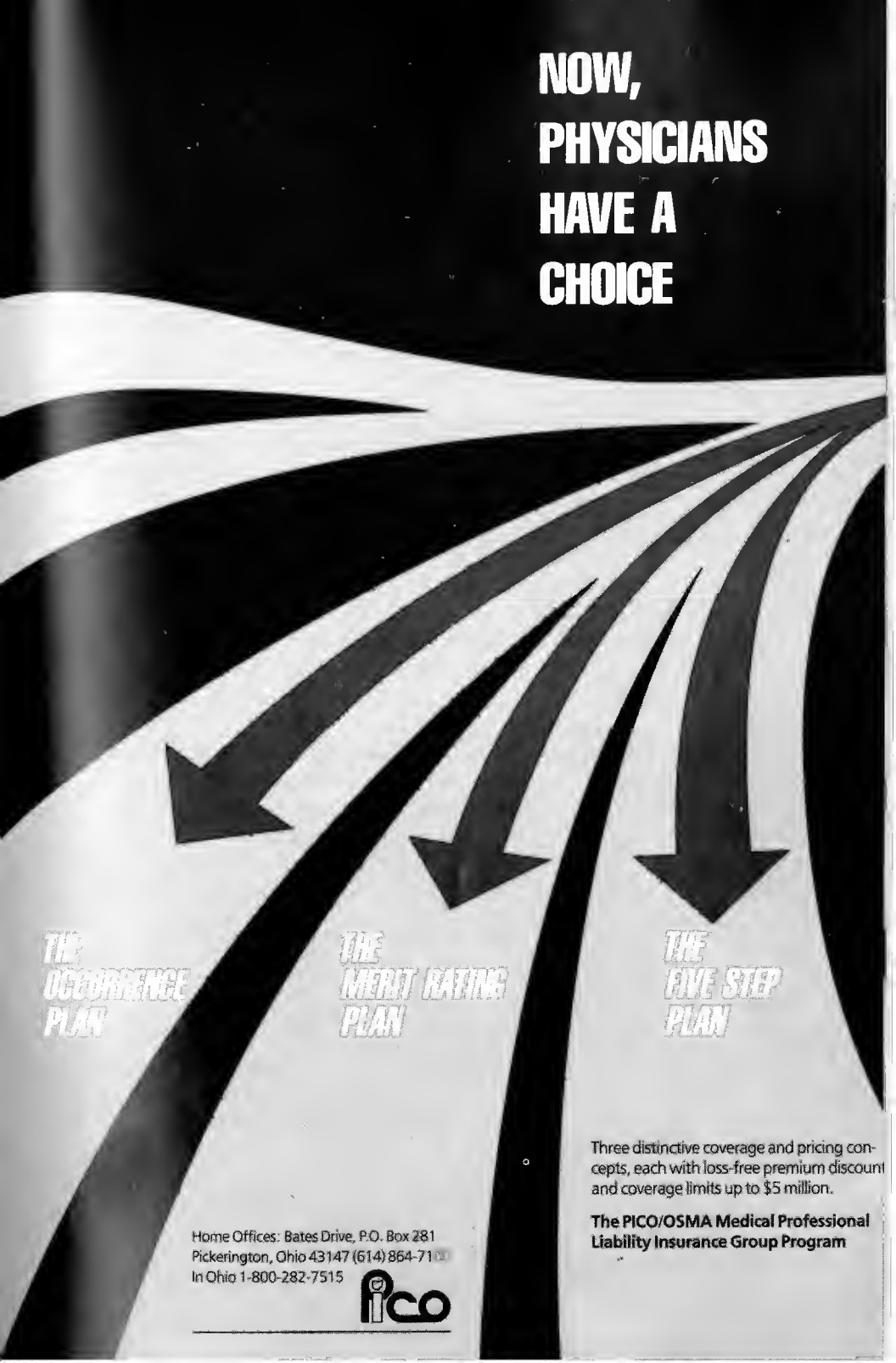
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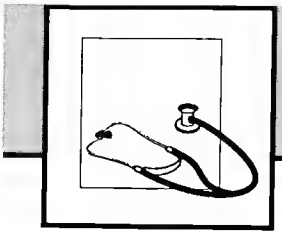

Physician's Advisory

Warning: report different levels of service.

Don't assume all your patient visits will average out to one or two reportable levels. Calling them all "intermediate," for instance, may lead you to big trouble with Medicare.

In a recent seminar for P-M Group medical management consultants. Ms. Jacque Leopold gave an important warning.* She said that physicians reporting all their office visits, hopital visits and/or consults at the same "level" may find themselves in trouble with Medicare authorities. Doctors who charge each office visit they perform as an "i.o.v." (intermediate office visit) may be in for problems.

Many Levels

Medicare recognizes a number of service levels for which it will reimburse:

- Minimal
- Brief
- Limited
- Intermdeiate
- Extended
- Comprehensive

Each level specifically defines what's involved, and your chart notes should correspond with the definitions.

Don't follow the common assumption that your office visits (or hospital visits or consults) average out to "intermediate," reporting them all at that level. Worse still, don't follow this approach except for charging unusually long visits as "extended."

Medicare considers it statistically impossible for a doctor to have just the two levels of service. The fact that they might average out that way, if true at all, does not excuse you from liability for overcharging the shorter visits that were really "minimal," "brief" or "limited."

This issue is cropping up dramatically in Florida, where HCFA is pursuing a number of physicians who reported only two levels. The average settlement being repaid to Medicare is $70,000!

Chart Notes Are Key

Don't report the level of service simply on the basis of time you spent with the patient, let what you write or dictate as a progress report in the patient's chart justify the extent of the visit. As Ms. Leopold puts it: "You're sunk if the chart notes don't match the kind of visit reported."

*Ms. Leopold is with Karen Zupko & Associates, One Magnificent Mile, 980 North Michigan Avenue, Suite 1325, Chicago, IL, 60611; phone (312) 642-5616.

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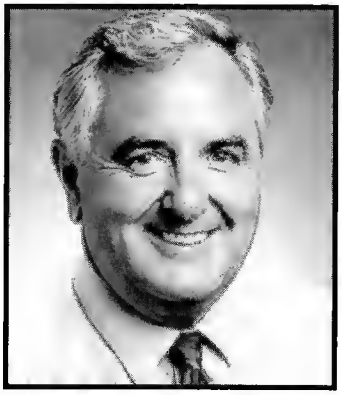

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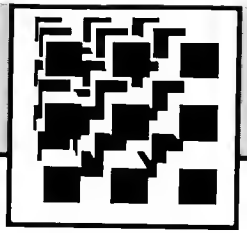


Western Reserve Care System-CME

November 11, 1989 - 8:00 a.m., Anesthesiology Lecture Series, "Common Blocks in the Pain Clinic" Donald L. Person, M.D., Anesthesiologist, Western Reserve Care System, Anesthesia Conference Room - Northside Medical Center

November 11, 1989 - 8:00 a.m., Tumor Conference, Armand Garcia, M.D., Moderator, Clinical Assistant Professor of Surgery, NEOUCOM, General Surgeon, Western Reserve Care System, Hitchcock Auditorium - Southside Medical Center

November 11, 1989 - 9:00 a.m., Surgical Visiting Professor, "Management of Blunt Cardia Trauma" Thomas L. Higgins, M.D., Acting Director, Cardiothoracic ICU, The Cleveland Clinic Foundation, Cleveland, Ohio, Hitchcock Auditorium - Southside Medical Center

November 14, 1989 - 8:00 a.m., Emergency Medicine Lecture Series, "Hypertensive Emergencies and Treatment", L. Kevin Nash, M.D., Assistant Professor of Internal Medicine, NEOUCOM, Internist, Western Reserve Care System, Medical Education Center - Northside Medical Center

November 16, 1989
8:00 a.m. - 10:30 a.m.

Mini Cancer Symposium
Hitchcock Auditorium - Southside Medical Center

"Initial Presentation with Signs, Symptoms, Diagnostic Measures and Initial Surgical Treatment", Frances G. Couch, M.D.

"Pathology of Epithelial Tumors of the Ovary and Staging"
Shokat Fatteh, M.D.

"The Role of the General Surgeon in the Treatment of Cancer of the Ovary at WRCS and Second Look Operation", Abdul Ghani, M.D.

"Chemotherapy in Cancer of the Ovary", Masud R. Bhatti, M.D.

"The Role of Radiation Therapy", Robert J. Piroli, M.D.

November 16, 1989
8:00 a.m. - 11:15 a.m.

Child Abuse and Neglect Mini Symposium
Medical Education Center, Northside Medical Center

"Indicators of Physical Abuse and Neglect"
Michael J. Durfee, M.D.

"Now What? - Psychological Treatment"
Michael J. Durfee, M.D.

Faculty Panel Discussion:
Gregory X. Boehm, M.D., Wilfred B. Dodgson, M.D., Michael J. Durfee, M.D., Dale L. Kile, Jr., M.D., Craig H. Neuman, J.D., Madeleine Ortiz, M.D., Moderator

November 16, 1989
1:00 p.m. - 6:00 p.m.

Opthalmology Symposium
Squaw Creek Country Club, Vienna, Ohio

"Modern Perceptions of Glaucoma"

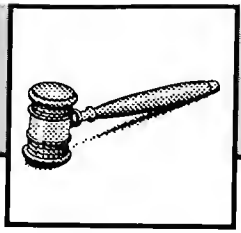
"Pharmacology and Physiology of the Recent Anti-Glaucoma Medications: Including Alpha and Beta Blockers"

"Review of the Latest Laser and Surgical Glaucoma Procedures"

Barry J. Leader, M.D.
Clinical Assistant Profesor of Opthalmology, Tulane University School of Medicine, Director, Glaucoma Treatment Center, Eye, Ear Nose and Throat Hospital, New Orleans, Louisiana.

November 18, 1989 - 8:00 a.m., Anesthesiology Lecture Series, "Spinal, Epidural, Caudal Anesthesia" Darlene M. Miller, M.D. , Assistant Professor of Anesthesiology, NEOUCOM, Pediatric Anesthesiologist, Western Reserve Care System, Anesthesia Conference Room, Northside Medical Center.

November 18, 1989 - 8:00 a.m., Tumor Conference, David G. Reed, M.D., Moderator, Otolaryngologist, Western Reserve Care System, Hitchcock Auditorium, Southside Medical Center



Legislative Update

On September 27, 1989 Senate Bill 13, (Ohio's Durable Power of Attorney for Health Care Law) sponsored by Senator Richard Pfeiffer (D-Columbus) became effective.

The durable power of attorney for health care is the first step taken by the legislature to address the issue of prolonging the life of terminal patients by mechanical or artificial means, despite the patient's or family's desire to discontinue or withhold such treatment. This follows over 10 years of debate on the emotional issue by proponents and opponents of the living will concept. While Senate Bill 13 does not authorize the creation of a living will (in which an individual would expressly state his desires about life-prolonging procedures), it does not provide for the designation of a surrogate decision-maker empowered to make most health care decisions including the withholding or withdrawal of life-prolonging measurers.

In executing a durable power of attorney for health care, the new law allows for the use of a preprinted form that can be completed without the involvement of a lawyer

The OSMA has developed a brochure and form entitled "Health Care Decisions: Who Makes Them When You Can't" for distribution to patients. The forms are available from the Society office, (788-4700).

Dear Friends,

The auxiliary is sponsoring a holiday sharing card as a fund-raising project for the American Medical Association Education and Research Foundation (AMA-ERF). A lovely holiday greeting card will be sent to each society member and their spouse. An enclosure card listing the names of all those who make a donation will be included in the greeting. We hope you will choose to have your name as part of this list.

The American Medical Association Education and Research Foundation (AMA-ERF) was established nearly forty years ago to help support quality education in the nation's medical schools. Two of the AMA-ERF funds are

- The Medical School Excellence Fund provides grants to medical schools to use as they see fit.
- The Medical Student Assistance Fund provides funds to medical schools for student financial aid.

From its modest beginnings in 1950, the AMA-ERF has consistently supported quality medical education in the United States. The extraordinary fund-raising efforts of the AMA Auxiliary and the generosity of contributing medical families have secured AMA-ERF's past effectiveness and assure its future success.

AMA-ERF

American Medical Association Education and Research Foundation

By supporting this project you will enjoy the following advantages:

1. Your AMA-ERF donation is TAX DEDUCTIBLE.
2. The holiday sharing card involves NO LABOR on your part. (The committee does all the work.)
3. Your special HOLIDAY WISHES will be conveyed to the members of the Mahoning County Medical Society and Auxiliary.
4. Your donation is an investment in the future of good health care in this country.
5. You will be performing a service to the auxiliary by helping us to help others.

Here is the simple procedure to follow: Just send me your tax deductible check for $ __________ together with the contribution form below. Do it now, before the holiday rush begins. Please make checks payable to AMA-ERF.

Remember, this is a charitable cause—one to which we have a deep commitment. Please be generous and let us hear from you soon. Deadline — December 1st.

- -

Mahoning Medical Society
AMA-ERF HOLIDAY SHARING CARD PROJECT

Contributor ______________________________

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City ______________ State ______________ Zip Code ______________

Amount of Contribution $ __________ School to Receive Contribution ______________

Fund to Receive Contribution: (check one)

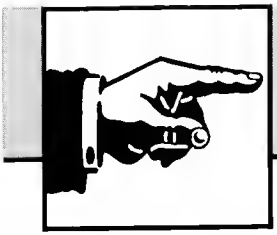
☐ Medical School Excellence Fund ☐ Medical Student Assistance Fund

Signature ______________________________ Date ______________

Please make your check payable to AMA-ERF and send it with this form to:

Pauline Sarantopoulos
170 Newport Drive, Boardman, OH 44512

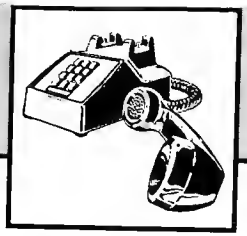
PS/10/89



Important Notice

Effective December 1, 1989, physicians who treat medicare patients referred to them by other physicians will be required to include the referring physician's Provider Identification number (PIN) on the HCFA 1500 forms. This means that the treating physician must have the PIN for all other physicians who refer patients to him or her.

To assist physicians with this requirement, the Mahoning County Medical Society has obtained a complete listing of providers in Mahoning County from the OSMA. Please call the office (788-4700) for your copy.



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